Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROPER PAYMENTS FOR MEDICAID PEDIATRIC DENTAL SERVICES

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EXECUTIVE SUMMARY

OBJECTIVE

To assess the appropriateness of Medicaid payments for pediatric dental services during calendar year 2003 in five States.

BACKGROUND

Improper Medicaid payments for dental services have been identified periodically by State Medicaid Fraud Control Units (MFCU). In 2004, a MFCU investigation determined that dentists were reimbursed $4.5 million for unnecessary dental services. In 2000, another MFCU identified a widespread fraud scheme by dentists who recruited children to receive Medicaid-reimbursable services, many of which were unnecessary or were not provided.

In 1967, Congress established the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program under Medicaid to ensure that children and youth receive routine and preventive health care services. To meet the EPSDT requirements, States must provide routine services to children and youth, even if these services are not available to other needy populations in the State's Medicaid program.

Federal regulations require State Medicaid programs to ensure that claims for EPSDT services are accurate, supported by documentation, and provided as medically necessary. The Medicaid policies established in each of the five States we reviewed also included these requirements.

In this report, we examined a stratified random sample of Medicaid pediatric dental services provided in five States during 2003 to determine whether the services met requirements for proper documentation, billing, and medical necessity.

FINDINGS

Thirty-one percent of Medicaid pediatric dental services in the five States resulted in improper payments. In the five States we reviewed, improper payments for pediatric dental services provided during calendar year 2003 totaled an estimated $155 million, of which the Federal share was approximately $96 million.

An estimated 24 percent of services had documentation errors that prevented medical record reviewers from determining whether the services were medically necessary and/or billed appropriately.

Documentation errors accounted for $138 million (89 percent) of the total improper payments we identified.

In addition, 7 percent of services did not meet billing requirements and 2 percent were medically unnecessary. The total percentage of errors exceeds 31 percent because some services had more than one type of error.

Documentation errors accounted for the largest amount of improper payments in all five States. Improper Medicaid payments for pediatric dental services ranged from an estimated $3 million to $78 million in the five States we reviewed. Despite this variation among the States, the majority of improper payments in each State were due to documentation errors. Payments for services with documentation errors ranged from 75 percent to 94 percent of a State's total improper payments for pediatric dental services.

RECOMMENDATIONS

We found that 31 percent of the Medicaid pediatric dental services provided in calendar year 2003 in the five States we reviewed resulted in estimated improper payments of $155 million. Documentation errors were the most common, resulting in $138 million of the total improper payments (89 percent).

Without the required documentation, State Medicaid agencies, medical record reviewers, or other oversight authorities cannot determine the appropriateness of services. Accordingly, we recommend that the Centers for Medicare & Medicaid Services (CMS) take the following actions to reduce documentation errors for Medicaid pediatric dental services:

Increase Efforts to Ensure That States Enforce Existing Policies Relating to the Proper Documentation of Pediatric Dental Services

For example, CMS can assist States in targeting medical reviews and or developing prepayment edits to ensure appropriate documentation of certain pediatric dental services.

Provide Assistance to States to Promote Provider Awareness and Ensure Compliance with Documentation Requirements

For example, CMS can assist States with developing educational brochures for Medicaid pediatric dental providers that emphasize the importance of documentation.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS did not indicate whether it concurred with our recommendations. Rather, CMS stated that it "does not disagree" with our recommendations and that our recommendations dovetail into the Medicaid Integrity Group's charge to provide effective support and assistance to States. Where appropriate, we made changes to the report in response to CMS's technical comments.

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INTRODUCTION

OBJECTIVE

To assess the appropriateness of Medicaid payments for pediatric dental services during calendar year 2003 in five States.

BACKGROUND

Title XIX of the Social Security Act established Medicaid in 1965 as a Federal-State partnership to provide certain basic services to categorically and medically needy populations.[1] The program currently serves approximately 58 million people, including children, the aged, the blind, the disabled, and people who are eligible to receive Supplemental Security Income.[2]

States have flexibility in designing their Medicaid programs; however, they must meet certain minimum requirements to receive Federal matching funds. Within these broad Federal requirements, "each State decides eligible groups, types and range of services, payment levels for services, and administrative and operating procedures" for its Medicaid program.[3]

Improper Medicaid Payments for Dental Services

Improper Medicaid payments for dental services have been identified periodically by State Medicaid Fraud Control Units (MFCU).[4] Improper payments include "any payment that should not have been made or was made in an incorrect amount under statutory, contractual, administrative or other legally applicable requirement."[5]

In 2004 an investigation by California's MFCU led the State Attorney General to file charges against 20 dentists for defrauding California's

[1] 42 U.S.C. §§ 1396-1396v; sections 1901-1936 of the Social Security Act.

[2] Medicaid Statistical Information System State Summary Datamart, based on 2004 data. Available online at http://msis.cms.hhs.gov. Accessed on January 2007.

[3] Program description of Grants to States for Medical Assistance Programs: 42 CFR § 430.0.

[4] Under section 1902(a)(61) of the Social Security Act, each State is responsible for operating a MFCU unless it would not be cost effective. MFCUs investigate and prosecute violations of State Medicaid provisions and review complaints of abuse or neglect. Section 1903(q) of the Social Security Act describes State requirements for fraud control.

[5] "Implementation Guidance for the Improper Payments Information Act of 2002, Public Law 107-300," Chief Financial Officers Council-President's Council on Integrity and Efficiency Erroneous and Improper Payments Work Group.

Medicaid Program, abusing children and elders, and intentionally inflicting bodily injury.[6] The dentists unnecessarily performed root canals, drilled into patients' healthy teeth, and completed as many as 20 medically unnecessary filling procedures on the same patient, defrauding the Medicaid program of $4.5 million.

In 2000, Florida's MFCU investigated a widespread Medicaid fraud scheme by dentists who recruited children to receive Medicaid-reimbursable services. Many of the services were found to be unnecessary or not provided.[7]

In fiscal year 2006, the Centers for Medicare & Medicaid Services (CMS) implemented a program designed to estimate and monitor State and national improper payment rates in the Medicaid program.[8] However, CMS does not estimate improper payment error rates for specific services (e.g., dental services) at the State or national levels.

Medicaid Coverage of Pediatric Dental Services

In 1967, Congress established the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program under Medicaid. The EPSDT program requires States to provide children and youth with routine and preventive health care services that normally may not have been provided through the Medicaid program. To meet the EPSDT requirements, States must provide dental screenings and all medically necessary diagnostic, preventive, and treatment services to children and youth, even if these services are not available to other needy populations in the States' Medicaid programs.[9]

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[6] "Dentists Accused of Fraud, Assault," San Francisco Chronicle. September 23, 2004. Available online at http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2004/09/23/MNGQK8TI8U1.DTL&hw=Medi+cal+dental&sn=012&sc=224 . Accessed on November 9, 2006.

[7] "13 Arrested For Medicaid Fraud at South Florida Dental Clinics," Office of the Attorney General of Florida. December 7, 2000. Available online at http://myfloridalegal.com/newsrel.nsf/newsreleases/634AAC1241EADF5B852569AE004F64B7 . Accessed on October 5, 2006.

[8] CMS implemented the Payment Error Rate Measurement program in fiscal year 2006 to comply with Public Law 107-300. Available online at www.amchp.org/policy/PERM1.pdf. Accessed on March 9, 2006.

[9] The Federal EPSDT requirements are described in 42 CFR § 441.56. States must offer these services to children and youth under 18 years of age but may choose to extend eligibility through age 21. All five States examined in our study offered EPSDT coverage to beneficiaries up to age 21 in 2003.

In 2003, Federal and State spending on all Medicaid dental services totaled $3 billion.[10] In this report, we analyzed Medicaid pediatric dental services provided during calendar year 2003 in five States (Idaho, Indiana, Massachusetts, North Carolina, and Texas), hereafter referred to as States A-E.[11] In the five States, pediatric dental services cost $555 million in 2003.[12] This amount represented over 90 percent of Medicaid payments for all (adult and pediatric) dental services in the five States.[13] Furthermore, pediatric dental services in the five States accounted for over 18 percent of the national Medicaid expenditures for pediatric dental services provided in 2003.

Federal and State Medicaid Requirements for Claims Payments

Federal regulations require State Medicaid programs to ensure that claims are supported by documentation and accurately billed. Specifically, to ensure that claims are supported by documentation, States must require providers to "[k]eep any records necessary to disclose the extent of services the provider furnishes."[14] To ensure accurate billing, States are required to include a statement on the claim forms that, when signed by the provider, certifies the accuracy and completeness of information submitted for reimbursement of services.[15] Finally, Federal law requires States to ensure that services are provided to the EPSDT population as medically necessary. In addition, the EPSDT benefit requires States to provide "[s]uch other necessary health care to . . . correct or ameliorate defects," or conditions.[16]

Federal regulations permit States to set billing and documentation requirements for specific services offered under their EPSDT program.[17] Examples of service-specific requirements include restrictions on the

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[10] Medicaid Budget and Expenditure System dental claims for fiscal year 2003.

[11] In this report, the letters A-E refer to the same States throughout the report but do not correspond to the order of States as they are listed here.

[12] The Federal share of this total was approximately $344 million. Pediatric dental claims data were obtained directly from the States.

[13] Payments for all Medicaid dental services (both adult and pediatric) in the five States totaled $610 million in fiscal year 2003 (Federal share of approximately $376 million). Medicaid Budget and Expenditure System dental claims for fiscal year 2003.

[14] Required provider agreement, 42 CFR § 431.107(b)(1).

[15] Provider's statements on claims forms, 42 CFR § 455.18(a)(1).

[16] Social Security Act § 1905(r)(5). This requirement applies specifically to EPSDT services.

[17] 42 CFR §§ 441.58(a) and 441.56(b)(2) allow States to use "reasonable standards of medical and dental practice" to determine the frequency of services. 42 CFR §440.230(d) allows States to place appropriate limits on a service.

frequency of services that can be provided within a specific timeframe, such as the number of cleanings per year, and limitations based on the patient's age.

METHODOLOGY

We used peer medical record review to evaluate a sample of Medicaid pediatric dental services provided during calendar year 2003 in States A-E. See Appendix A for additional information about our methodology.

Sample Selection

Our sampling universe was limited to fee-for-service Medicaid pediatric dental services that were provided during calendar year 2003 in States A-E. To select the five States, we ranked all 50 States by Medicaid dental spending in fiscal year 2002 and eliminated States that used managed care to pay for any portion of their dental services. We also selected States based on the availability of the States' data in the Medicaid Statistical Information System database at the time of data collection, the percent of Medicaid spending on pediatric dental services, and the regional and economic diversity of the States.

Using information from each State's Medicaid Management Information System (MMIS) database, we constructed a stratified sample of 2,000 pediatric dental services. To improve our estimates, we stratified our population based on Medicaid allowed payments. Each State's population was divided into 3 strata, for a total of 15 strata. We excluded services rendered by providers that were under investigation at the time of our study, reducing our sample size to 1,824 services.[18]

Medical Record Review

We requested medical records from the providers in our sample of 1,824 services and received records for 96 percent of the services (1,744 services). The remaining 4 percent of services with medical records that were not provided (80 services) are included as undocumented errors in our results.[19] We contacted nonresponding providers at least three times to obtain the medical records. To ensure that they had received our requests, we telephoned providers that failed to respond to our original and follow-up written requests.

[18] See Table 3 of Appendix A for population and sample information, before and after excluding providers under investigation.

[19] An error is defined as a violation of one or more State requirement.

Certified professional coders and licensed dentists reviewed the records obtained from providers. All coders had experience in performing medical record reviews, and the dentists were all licensed to practice in at least one State. These medical record reviewers used 2003 State Medicaid policies that included requirements specific to the EPSDT services to identify documentation and billing errors. Each State's policies were used to identify errors in the services from that State. For example, the medical record reviewers used 2003 Texas Medicaid policies to examine services in our sample provided in Texas.[20] To determine whether services were medically necessary, the medical record reviewers used State and Federal standards of medical necessity for services provided to the EPSDT population.[21]

Error Categorization

We grouped the services that had errors into three categories—documentation errors, billing errors, and medical necessity errors. To provide more detailed information regarding the type of errors we identified, we categorized the primary error categories into subcategories where appropriate.

For example, we further categorized documentation errors as those that were insufficiently documented and those that were undocumented. We further categorized billing errors as services that had incorrect procedure codes (upcoded and downcoded), were not billable, were unbundled, and were billed with an incorrect number of units. Appendix A contains a more detailed description of these categories and subcategories.

Data Analysis

We analyzed the medical record review results in SAS, a software program used for statistical analysis. Specifically, for each of the three error types, we statistically projected the error percentages and the improper payments for Medicaid pediatric dental services provided during 2003 in the five States. We calculated the improper payments based on the amount paid for the services as specified in each State's MMIS database.

[20] Quality assurance steps, such as interrater reliability testing to ensure consistency among the reviewers, were used throughout the review process. See "Quality Assurance" in Appendix A for more information.

[21] Social Security Act §§ 1905(r)(3) and (5).

For services that were upcoded, downcoded or unbundled or had the incorrect number of units, we considered only a portion of the payment for the service to be improper. We determined the improper amount for each of these services by calculating the difference between the Medicaid payment made to the provider and the payment that should have been made based on our medical record review. For all other services (i.e., services with documentation errors, medically unnecessary services, and services that were not billable), we considered the entire amount paid to the provider to be improper.

Limitations

Our results cannot be extrapolated nationally, to other States, or beyond the timeframe of our evaluation. Accordingly, we make no inferences about improper payments outside our evaluation scope.

Standards

This evaluation was conducted in accordance with the "Quality Standards for Inspections" issued by the President's Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

Thirty-one percent of Medicaid pediatric dental services in the five States resulted in improper payments

In the five States we reviewed, 31 percent of Medicaid pediatric dental services provided during calendar year 2003 did not meet documentation, billing, and medical necessity requirements (see Table 1). Improper payments for these services totaled an estimated $155 million, of which the Federal share was approximately $96 million.[22]

Table 1: Error Rates for Medicaid Pediatric Dental Services Provided in Five States, 2003

Type of Error	Services (Percentage)	Amount Paid (Millions)
Documentation	24%	$138
Billing	7%	$12
Medically Unnecessary	2%	$12*
(Overlapping errors)**	(2%)	($7)*
Total Errors	**31%**	**$155**

* Relative precision is too large to confidently project.

** Overlapping errors are subtracted to obtain the category's total.

Source: Office of Inspector General medical record review of Medicaid pediatric dental services.

Appendix B (Tables 5-10) gives the point estimates and confidence intervals for the errors and improper payments listed in Table 1 and Appendix C (Tables 11-13) provides further detail on the errors and improper payments we found.

Twenty-four percent of services had documentation errors

Documentation errors were the most common type of error.[23] An estimated 24 percent of pediatric dental services provided during calendar year 2003 in the five States did not meet documentation requirements. Specifically, 18 percent were insufficiently documented and 6 percent were undocumented.[24] In total, these services

[22] This estimate is calculated based on a 62-percent Federal share of Medicaid dental expenditures in 2003.

[23] The documentation error rate was statistically different from both the billing error rate and the medically unnecessary error rate at the 95-percent confidence level.

[24] See Appendix B for the point estimates and confidence intervals for insufficiently documented and undocumented subcategories.

represented an estimated $138 million of the improper payments we identified (see Appendix C, Table 11). Without the required documentation, medical record reviewers could not determine whether these services were medically necessary and/or billed appropriately.

Insufficiently Documented Services

Of those services that had documentation errors, almost three-fourths were insufficiently documented. Therefore, the medical record reviewers were unable to determine whether these services were medically necessary, billed correctly, or both.

An estimated 18 percent of pediatric dental services had insufficient documentation. Specifically, 13 percent were insufficiently documented to determine if the services were medically necessary and 9 percent were insufficiently documented to determine if the services were billed correctly. An additional 4 percent of services had insufficient documentation to determine whether the services were both medically necessary and billed correctly and were, therefore, subtracted from the total to prevent double counting. In total, insufficiently documented services accounted for an estimated $103 million of the improper payments.

Examples of services that were insufficiently documented to determine medical necessity included (1) a procedure that was supported by an inconclusive (unreadable) x-ray and (2) a crown placement that was supported by a record that did not include an x-ray of the tooth.

Examples of services that were insufficiently documented to determine correct billing included medical records that indicated that the provider (1) performed a restoration on particular teeth but did not identify the tooth surfaces that were restored and (2) removed an impacted tooth but failed to indicate the type of removal (information that affects reimbursement of the service).[25]

Undocumented Services

Of those services that had documentation errors, over one-fourth were undocumented. Undocumented services either had no documentation or were unsubstantiated by the documentation submitted.

An estimated 6 percent of pediatric dental services were undocumented. Specifically, we did not receive documentation for 4 percent of services

[25] Partially and completely bony removals are reimbursed different amounts.

in our sample, and 2 percent of services were unsubstantiated by the documentation submitted. Undocumented services accounted for an estimated $34 million of the total improper payments.[26]

Examples of unsubstantiated services included those for which the records submitted by the providers contained only the account ledger (a financial document used by the providers to claim reimbursement) and records that lacked clinical treatment notes describing the medical aspect of the services.

Seven percent of services had billing errors

An estimated 7 percent of pediatric dental services provided during calendar year 2003 in the five States had billing errors. Billing errors included services billed with incorrect procedure codes, services that were not billable because they violated a Federal or State requirement for reimbursement, unbundled services, and services billed with the incorrect number of units.[27] In total, billing errors accounted for an estimated $12 million of the improper payments (see Appendix C, Table 12).[28]

Examples of services with incorrect procedure codes included upcoded and downcoded services. Specifically, a limited oral exam was billed as a service that had a higher reimbursement rate (upcoded service), and a tooth extraction was billed as a service that had a lower reimbursement rate (downcoded service).

Examples of services that were not billable included two orthodontic adjustments billed in the same month, violating the State's limitation on the frequency for that service. Also, an anesthesia was billed separately from a restorative procedure performed on the same day. However, according to the State's policy, restorations include payment for anesthesia.

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[26] The estimated improper payments for insufficiently documented and undocumented services are rounded and, therefore, do not equal the improper payments for all documentation errors when summed.

[27] Unbundled services are billed using multiple individual codes rather than a single appropriate code for the combination of services described in the dental record.

[28] For services that were upcoded, downcoded or unbundled or had the incorrect number of units, we did not consider the entire payment for the service to be improper. We calculated the improper amount as the difference between the payment made by Medicaid and the appropriate payments that should have been made for each of the services.

Two percent of services were medically unnecessary

An estimated 2 percent of pediatric dental services provided during calendar year 2003 in the five States were medically unnecessary. These services represented an estimated $12 million of the total improper payments.[29]

Examples of medically unnecessary services included a root canal performed on a primary tooth that was ready to fall out, crowns placed on teeth that did not have large areas of decay warranting that level of restoration, and sealants inappropriately applied to primary teeth.

Documentation errors accounted for the largest amount of improper payments in each of the five States

In the five States we reviewed, improper Medicaid payments for pediatric dental services ranged from an estimated $3 million to $78 million. Despite this wide variation among the States, the majority of improper payments in each State were due to documentation errors.[30]

As illustrated in Table 2, documentation errors represented between 75 percent and 94 percent of a State's estimated improper payments. In three of the five States, documentation errors accounted for at least 90 percent of total improper payments.

Table 2: Improper Payments for Services With Documentation Errors in the Five States

State	Projected Improper Payments (Millions)		Percentage
	Documentation Errors	All Errors*	
A	$3.19	$3.38	94%
B	$25.32	$28.56	89%
C	$71.78	$77.91	92%
D	$24.18	$26.98	90%
E	$13.42	$17.88	75%
Total	**$137.88**	**$154.72**	**89%**

* Estimated improper payments do not include improper payments for services with overlapping errors.

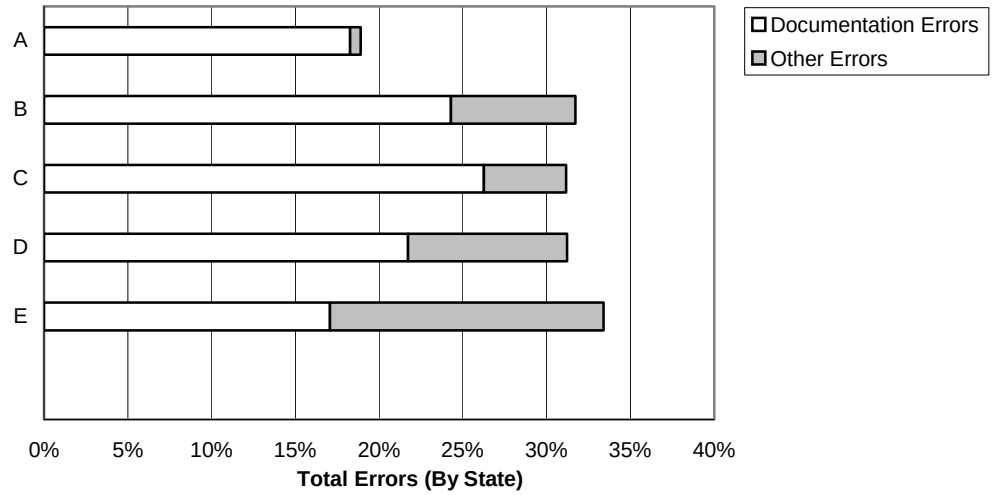
Source: Office of Inspector General medical review of Medicaid pediatric dental services.

[29] The relative precision equals 56 percent. See Appendix B for point estimates and confidence intervals.

[30] For each State we reviewed, the improper payments for services with documentation errors were statistically different from the improper payments for all other errors (billing and medical necessity) in that State at the 95-percent confidence level.

Furthermore, in four of the five States (States A, B, C, and D), documentation errors were more prevalent than billing and medical necessity errors combined.[31] The horizontal bars in Figure 1 (A-E) represent the overall error rate in each of the corresponding States. The overall error rate in each State is divided into documentation errors and other errors (billing and medical necessity errors, which are combined).

Figure 1. Comparison of Documentation and All Other Errors in the Five States



Note that estimated total error rates do not include overlapping errors.

Source: Office of Inspector General medical record review of Medicaid pediatric dental services.

For example, the overall error rate (total of documentation, billing, and/or medical necessity errors) in State A was approximately 19 percent. The documentation error rate in State A was 18 percent and less than 1 percent of services in State A were medically unnecessary or billed inappropriately. See Appendix D for the specific documentation error rates and overall error rates in each State.

[31] There is a statistical difference between the documentation error rate and all other errors in these four States.

We found that 31 percent of the Medicaid pediatric dental services provided in calendar year 2003 in the five States resulted in estimated improper payments of $155 million. These services did not meet Federal and State requirements for documentation, billing, and medical necessity of EPSDT services.

Documentation errors were the most common type of error. We estimate that documentation errors resulted in $138 million of the total $155 million in improper payments (89 percent).

Without the required documentation, State Medicaid agencies, medical record reviewers, or other oversight authorities cannot determine the appropriateness of services based on their medical necessity and/or their billing. Federal regulations and State Medicaid policies already specify requirements for the proper documentation of services. Accordingly, we recommend that CMS take the following actions to reduce documentation errors for Medicaid pediatric dental services:

Increase Efforts to Ensure that States Enforce Existing Policies Relating to the Proper Documentation of Pediatric Dental Services

For example, CMS can assist States in targeting medical reviews and or developing prepayment edits to ensure appropriate documentation of certain pediatric dental services.

Provide Assistance to States to Promote Provider Awareness and Ensure Compliance with Documentation Requirements

For example, CMS can assist States with developing educational brochures for Medicaid pediatric dental providers that emphasize the importance of documentation.

In addition to these recommendations, we will forward information on the miscoded, insufficiently documented, and medically unnecessary services in our sample to CMS for appropriate action.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS did not indicate whether it concurred with our recommendations. Rather, CMS stated that it "does not disagree" with our recommendations and that our recommendations dovetail into the Medicaid Integrity Group's charge to provide effective support and assistance to States.

CMS noted that this study was conducted in only five States and that the results cannot be extrapolated nationally, to other States, or beyond the timeframe under review. CMS questioned whether missing or incomplete documentation may have been stored electronically and not included in provider responses. While this is possible, providers are required, upon request, to provide legible and complete documentation to support claims. CMS also expressed concerns about children's access to Medicaid dental services. The objective of this report is to assess the appropriateness of Medicaid payments for pediatric dental services during calendar year 2003 in five States.

Where appropriate, we made changes to the report in response to CMS's technical comments. The full text of CMS's comments is provided in Appendix E.

DETAILED METHODOLOGY

Below, we elaborate on the methodology used to accomplish our objective.

Scope

Services in our universe were restricted to fee-for-service Medicaid dental services provided to children and youth under the age of 21 during calendar year 2003 in five States (Idaho, Indiana, Massachusetts, North Carolina, and Texas). These five States are referred to as States A-E.[32] We focused this evaluation on Medicaid pediatric dental services because, as required by the EPSDT program, States must provide Medicaid-eligible children and youth with initial and periodic examinations and medically necessary follow-up care, including dental care.

State Selection

We focused our evaluation on five States, which we selected based on the following characteristics:

- high total Medicaid dental expenditures;
- no managed care for Medicaid dental services;
- complete submission of Medicaid Statistical Information System data for 2002;
- percentage of Medicaid spending on pediatric dental services;
- variation in demographic characteristics (e.g., geographic distribution and economic characteristics); and
- overall Medicaid spending.

Sample Selection

Based on information from each State's MMIS database, we constructed a clustered sample of 2,000 pediatric dental services. To improve our estimates, we stratified our population based on Medicaid allowed payments. Each State's population was divided into 3 strata, for a total of 15 strata.

[32] In this report, the letters A-E refer to the same States throughout the report but do not correspond to the order of States as they are listed here.

We cross-checked the provider information for the services in our sample with the Office of Inspector General's Office of Investigations and the lists of active investigations compiled by each State's Medicaid Fraud Control Unit. We excluded services rendered by providers under active investigations. The excluded services reduced the expenditures for services in our sample from $202,650 to $188,298 and reduced our sample size to 1,824 services. Table 3 provides information about the sample size and population, before and after excluding services rendered by providers that were under investigation.

Table 3: Strata Definitions and Sizes for Sample and Population

Stratum Definition (Range of Amounts Paid in Stratum)	Sample		Sample Excluding Providers Under Investigation		Population		Population Excluding Providers Under Investigation	
	Services (Stratum Size)	Amount Paid*	Services (Records Requested)	Amount Paid*	Services	Amount Paid*	Services	Amount Paid*
$0.01 - $59.99	750	$21,345	687	$19,517	11,351,211	$302,959,310	11,128,821	$295,165,087
$60.00 - $129.99	750	$59,380	674	$53,458	1,996,044	$158,308,629	1,876,648	$148,457,863
$130.00 or more	500	$121,924	463	$115,322	414,797	$94,117,690	396,087	$90,908,971
Total	**2,000**	**$202,650**	**1,824**	**$188,298**	**13,762,052**	**$555,385,630**	**13,401,556**	**$534,531,922**

* Sample and population paid amounts are rounded to the nearest whole dollar figure.

Lines may not sum to totals due to rounding.

Source: Office of Inspector General analysis of calendar year 2003 Medicaid pediatric dental claims data in selected States.

Medical Record Review

We contracted with a medical record review company to collect medical records from providers. The contractor mailed initial record requests to the providers for the services in our sample. If necessary, follow-up requests were mailed 15 days later to those providers that had not yet responded and second follow-up requests were made by fax or telephone 15 days after the first followup. In addition, the contractor made further attempts to collect medical records from the remaining nonrespondents.

We categorized the services for which these attempts were unsuccessful as undocumented. We spoke on the telephone with the staff of these providers to ensure that they received our original and follow-up written requests. Table 4, on the next page, lists each State's response rate and the response rate for the entire sample.

We did not conduct onsite visits to the providers that did not submit the requested medical records to follow up on the status of the records.

Further, we did not compare the information submitted with information that may have been saved electronically onsite (e.g., records with handwritten incorrect dates of service were not compared to the electronic records of the patients' appointments).

Table 4: Response Rates in States A-E

State	Records Requested	Records Received	Response Rate
A	386	373	96.6%
B	400	380	95.0%
C	351	328	93.4%
D	308	298	96.8%
E	379	365	96.3%
Total	**1,824**	**1,744**	**95.6%**

Source: Office of Inspector General analysis of Medicaid pediatric dental claims data.

The medical record review was conducted in two stages:

- Stage 1—Certified Professional Coder Review: Coders reviewed records for compliance with documentation and billing requirements. They determined whether each service was documented and billed correctly and noted when the documentation was insufficient to make these determinations.
- Stage 2—Licensed Dentist Review: Dentists reviewed records of services that were documented to determine whether they were medically necessary and noted when the documentation was insufficient to make determinations of medical necessity.

Quality Assurance. Prior to initiating the medical record review, all coders and dentists were asked to review 100 services (20 services per State) outside of our sample for quality assurance purposes. This interrater reliability testing ensured that the reviewers were completing the review instrument and interpreting the applicable regulations consistently. In addition, the contractor's project manager randomly checked coder and dentist review results throughout the review process, examined all results to ensure that they were completed correctly and consistently, and verified data entry.

Error Categorization

We grouped the services that had errors into three categories—documentation errors, billing errors, and medical necessity errors.[33] The criteria used to identify these errors included State Medicaid policies and Federal EPSDT regulations for documentation, billing, and medical necessity of the services.

Documentation errors: Federal regulations and State Medicaid policies from the five States we reviewed required providers to maintain and furnish documentation that substantiates the nature and extent of all services provided to the recipients. Therefore, payments for services that did not meet State documentation requirements were considered improper although the services may have been appropriate in terms of medical necessity and billing.

We categorized services that did not meet documentation requirements as either insufficiently documented or undocumented.

Insufficiently documented services lacked sufficient information to determine whether the services were medically necessary or correctly billed. These services were often missing a crucial piece of evidence, such as a test result, an x-ray, or a narrative to explain or support the billed service. We also included services supported by illegible documentation in this category.

Undocumented services consisted of services for which no documentation was provided and services that were unsubstantiated by their documentation. Records for unsubstantiated services did not support that any service had been provided on the date claimed or described a service that had already been claimed and paid.

Billing errors: This category includes a variety of errors for which the claim submitted for reimbursement contained information that was inconsistent with the documentation in the patient's dental record.

Billing errors included services that were billed by the provider using the incorrect procedure codes (i.e., miscoded services). Miscoded services were categorized as upcoded when the provider submitted a procedure code that had a higher reimbursement than the procedure code for the service described in the dental record. Miscoded services were categorized as downcoded when the submitted procedure code

[33] These three categories were based on the information obtained from the five State Medicaid policies.

resulted in a lower reimbursement than the procedure code for the service described in the dental record.

In addition, billing errors included services that were not billable because they violated a Federal or State guideline required for reimbursement. State guidelines that pertained to specific services included, for example, limitations on the frequency of services or the patient's age. Because States establish these guidelines, they sometimes varied by State.

We also included unbundled services in the billing error category. Unbundling occurs when the provider bills for the service using multiple individual procedure codes rather than a single appropriate code for the combination of services described in the dental record.

Finally, billing errors included services that had records with incorrect information, such as the wrong number of units (i.e., teeth and tooth surface) as compared to the claim.

Medical necessity errors: This category included services that did not meet the EPSDT medical necessity requirement and violated established criteria prescribing the appropriate conditions under which the service should be provided.

Errors with no payment effect: We identified 114 services that did not affect the payment of the services; thus, these services were not included in our error calculations. These services had the following errors: incorrect procedure code (but the same reimbursement rate as the code submitted), incorrect tooth number, incorrect tooth surface, and incorrect date.

Data Analysis

We analyzed the medical record review results in SAS, a software program used for statistical analysis. For each of the three error categories, we statistically projected the error percentages and the improper payments that were allowed by Medicaid for pediatric dental services provided during 2003 in the five States. We also calculated the improper payments based on the amount paid for the services as specified in each State's MMIS database.

For services that were upcoded, downcoded or unbundled or had the incorrect number of units, we considered only a portion of the payment for the service to be improper. We determined the improper amount for each of these services by calculating the difference between the payment made by Medicaid to the provider and the payment that should have

been made according to the results of the medical record review. For all other services (i.e., services with documentation errors, medically unnecessary services, and services that were not billable), we considered the entire amount paid to the provider to be improper.

See Appendix B for the point estimates and confidence intervals of the errors and improper payments in the three error categories. Also, see Appendix C for a detailed list of the different errors and improper payments associated with the error subcategories.

APPENDIX B

Point Estimates and Confidence Intervals for Errors and Improper Payments, Medicaid Pediatric Dental Services Provided During 2003 in States A-E

Table 5: Estimates of Errors

Error	Point Estimate	95-Percent Confidence Interval
Insufficiently documented services	*17.6%*	*13.8% - 21.4%*
*Undocumented services**	*6.5%**	*4.3% - 8.6%*
Total documentation errors	24.1%	20.0% - 28.2%
Billing errors	7.3%	4.9% - 9.8%
Medically unnecessary errors	1.8%	0.6% - 3.1%
Overlapping errors	(2.3%)	0.5% - 4.1%
Total percentage of services that did not meet Medicaid requirements	**30.9%**	**26.5% - 35.3%**

Shaded regions represent error subcategories.

* Estimate rounded up from 6.46 percent.

Source: Office of Inspector General medical record review results, 2006.

Table 6: Estimates of Improper Payments

Error	Point Estimate	95-Percent Confidence Interval
Insufficiently documented services	*$103,395,993*	*$65,219,781 - $92,376,038*
Undocumented services	*$34,488,689*	*$27,627,518 - $41,349,861*
Total documentation errors	$137,884,683	$120,880,396 -$154,888,969
Billing errors	$12,113,796	$7,248,004 - $16,979,587
Medically unnecessary errors*	$11,777,685	$5,197,559 - $18,357,811
Overlapping errors**	($7,060,484)	$480,471 - $13,640,497
Total amount improperly paid (paid for services that did not meet Medicaid requirements)	**$154,715,679**	**$137,378,140 - $172,053,218**

Shaded regions represent error subcategories.

* Relative precision for this estimate equals 56 percent.

** Relative precision is too large to confidently project.

Source: Office of Inspector General medical record review results, 2006.

Table 7: Estimates of Improper Payments for Documentation Errors by State

State	Point Estimate	95-Percent Confidence Interval
A	$3,194,156	$2,390,295 - $3,998,018
B	$25,317,124	$20,996,594 - $29,637,655
C	$71,781,397	$56,291,098 - $87,271,696
D	$24,175,769	$19,516,426 - $28,835,113
E	$13,416,235	$10,557,261 - $16,275,210

Source: Office of Inspector General medical record review results, 2006.

Table 8: Estimates of Improper Payments for All Errors by State

State	Point Estimate	95-Percent Confidence Interval
A	$3,383,541	$2,571,454 - $4,195,628
B	$28,562,425	$24,176,361 - $32,948,489
C	$77,911,242	$62,201,055 - $93,621,428
D	$26,980,293	$22,154,415 - $31,806,170
E	$17,878,178	$14,623,313 - $21,133,044

Source: Office of Inspector General medical record review results, 2006.

Table 9: Estimates of Documentation Error Rates by State

State	Point Estimate	95-Percent Confidence Interval
A	18.3%	12.8% - 23.7%
B	24.3%	19.2% - 29.4%
C	26.1%	19.4% - 32.8%
D	21.7%	16.6% - 26.9%
E	17.1%	12.9% - 21.3%

Source: Office of Inspector General medical record review results, 2006.

Table 10: Estimates of Error Rates by State

State	Point Estimate	95-Percent Confidence Interval
A	18.9%	13.5% - 24.3%
B	31.7%	26.2% - 37.3%
C	30.9%	24.0% - 38.0%
D	31.2%	25.0% - 37.4%
E	33.4%	27.4% - 39.4%

Source: Office of Inspector General medical record review results, 2006.

APPENDIX C

DETAILED ERROR SUMMARY

Tables 11-13 provide a detailed summary of the errors identified in the medical record review, accompanied by the error rates and improper payments, as projected to the population.

Table 11 lists the errors and improper payments associated with documentation errors; Table 12 lists the errors and improper payments associated with billing errors; and Table 13 lists the errors and improper payments associated with all three error categories (documentation, billing, and medical necessity) and gives the totals.

Table 11: Medicaid Pediatric Dental Services - Documentation Errors in Five States, 2003

	Sample		Population	
Type of Documentation Error	**Services**	**Amount Paid**	**Services (Percentage)**	**Amount Paid (Millions)**
Insufficient documentation to determine whether medically necessary	*292*	*$36,018*	*13.2%*	*$78,797,909*
Insufficient documentation to determine whether correctly billed	*131*	*$15,701*	*8.7%*	*$46,190,060*
*Both**	*(64)*	*($6,952)*	*(4.3%)*	*($21,591,976)*
Total insufficient documentation	359	$44,766	17.6%	$103,395,993
No documentation provided	*80*	*$9,768*	*4.1%*	*$20,921,415*
Unsubstantiated services (services not documented)	*58*	*$6,023*	*2.3%*	*$13,567,274*
Total undocumented	138	$15,791	6.5%**	$34,488,689
Total Documentation Errors	**497**	**$60,557**	**24.1%**	**$137,884,683**

Shaded regions represent error subcategories.

* Overlapping errors are subtracted to obtain the category's total.

** Estimate rounded up from 6.46 percent.

Lines may not sum to totals because of rounding.

Source: Office of Inspector General medical record review of Medicaid pediatric dental services.

Table 12: Medicaid Pediatric Dental Services - Billing Errors in Five States, 2003

	Sample		Population	
Type of Billing Error	**Services**	**Amount Paid**	**Services (Percentage)**	**Amount Paid (Millions)**
Upcoded	*33*	*$1,529*	1.8%	*$2,924,005**
Downcoded	*12*	*($211)*	0.7%	*($854,265)**
Total incorrect procedure code	45	$1,318	2.4%	$2,069,740*
No billable service	32	$1,184	*3.0%*	$8,365,999
Unbundled services	17	$200	1.8%	$1,148,501*
Incorrect number of units	6	$776	*0.1%*	$529,555*
Total Billing Errors	**100**	**$3,478**	**7.3%**	**$12,113,796**

Shaded regions represent error subcategories.

* Relative precision is too large to confidently project.

Lines may not sum to totals because of rounding.

Source: Office of Inspector General medical record review of Medicaid pediatric dental services.

Table 13: Medicaid Pediatric Dental Services - Total Errors in Five States, 2003

	Sample		Population	
Type of Error – All Categories	**Services**	**Amount Paid**	**Services (Percentage)**	**Amount Paid (Millions)**
Total documentation errors	497	$60,557	24.1%	$137,884,683
Total billing errors	100	$3,478	7.3%	$12,113,796
Total medically unnecessary	39	$4,559	1.8%	$11,777,685*
(Overlapping errors)**	(18)	($835)	(2.3%)	($7,060,484)
Total Errors	**618**	**$67,760**	**30.9%**	**$ 154,715,679**

* Relative precision is too large to confidently project.

** Overlapping errors are subtracted to obtain the category's total.

Lines may not sum to totals because of rounding.

Source: Office of Inspector General medical record review of Medicaid pediatric dental services.

APPENDIX D

Comparison of Documentation and Total Error Rates by State

Table 14: Documentation Error Rates in the Five States

State	Proportion of Services	
	Documentation Errors	Total Errors
A	18.3%	18.9%
B	24.3%	31.7%
C	26.1%	30.9%
D	21.7%	31.2%
E	17.1%	33.4%

Note that estimated total error rates do not include overlapping errors.

Source: Office of Inspector General medical record review results, 2006.

See Tables 9 and 10 of Appendix B for the confidence intervals associated with these estimates.

AGENCY COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

DATE: AUG 24 2007

TO: Daniel R. Levinson
Inspector General

FROM: Herb B. Kuhn
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Improper Payments for Medicaid Pediatric Dental Services" (OEI-04-04-00210)

The Centers for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services (Department) appreciates the opportunity to comment on the OIG draft report entitled: "Improper Payments for Medicaid Pediatric Dental Services." The objective of the report was to assess the appropriateness of Medicaid payments for pediatric dental services during calendar year 2003 in 5 States.

In 1967, Congress established the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to ensure that children and youth receive routine and preventive health care services. Federal regulations require State Medicaid programs to ensure that claims for EPSDT services are accurate, supported by documentation and provided as medically necessary. OIG examined a random sample of Medicaid pediatric dental services provided in 5 States to determine whether the services met requirements for proper documentation, billing, and medical necessity. The OIG found 31 percent of Medicaid pediatric dental services in the 5 States resulted in improper payments and that documentation errors accounted for the largest amount of improper payments in all 5 States.

The CMS does not disagree with the OIG recommendations, the first of which is to increase efforts to ensure that States enforce existing policies concerning the proper documentation of pediatric dental services. We appreciate OIG's offer to forward information on miscoded, insufficiently documented, and medically unnecessary services in its sample used for the Draft Report.

We also welcome OIG's input on the recommendation that assistance be provided to States to promote awareness and ensure compliance with documentation requirements.

It should be noted that one of the two main business operations that CMSO's Medicaid Integrity Group (MIG) is charged with is to provide effective support and assistance to States. MIG can be very useful working with States to disseminate information and promote awareness on this topic.

CMS Specific Comments

- Given that access to dental services for children is extremely difficult for States to assure, we are concerned that the report not appear to paint dentists in general as program abusers, lest even more dentists refuse to treat Medicaid children any longer. There are proven algorithms that identify dental overpayments and models that can point auditors to potential problem cases. CMS intends to provide States technical assistance on incorporating these into their claims and State Surveillance and Utilization Review System (SURS) monitoring activities in order to come to grips with the problem and also that CMS and States work behind the scenes with State Dental Associations to help raise awareness of the need for improved documentation.

- Our concern about not driving more dentists out of the Medicaid program is reinforced by the information in Appendix B of the report, which shows that a sizeable percentage of the dental services reviewed were in the $0 to $60 range (For example, at reimbursement levels that may be significantly lower than commercial insurance pays.). We think it would be instructive to do a follow-up study that determines how much the average child with insurance costs each year, adjusts for the Medicaid payment difference, and sees if dentists are providing the same level of care for all children. If Medicaid children are getting more care, then there may be a systemic problem. But it is just as possible that these children need more care because of diet, disability, general health status, etc.

- Any publicly released statements about the report should emphasize the statement on page 6 of the Report: the study was conducted in only 5 States and cannot be extrapolated nationally to other States or beyond the timeframe of the Report evaluation.

- The CMS had some concerns about a statement in Appendix A of the report (page 15) which indicates that the reviewers "....did not compare the information submitted with information that may have been saved electronically onsite (for example, records with handwritten incorrect dates of service were not compared to the electronic records of the patients' appointments)." Is it possible that certain elements of the documentation identified as missing or incomplete were actually stored electronically?

- On page 16, in the fourth paragraph under "Error Categorization," OIG gives examples of insufficiently documented services: "These services were often missing a crucial piece of evidence, such as a test result, an x-ray, or a narrative to

explain or support the billed service. We also included services supported by illegible documentation. . ." Again, is it possible that missing documentation or handwritten items that were illegible might be stored electronically? There is no doubt that the OIG study has identified real problems with providers being careless or taking shortcuts in documenting services. Nonetheless, we question whether the scope of the problem may be somewhat less than the report suggests because of data storage and other technological issues.

- On Page 19, the population and budget data in Appendix B, Table 5, has enough information to identify the individual States. CMS' Office of Clinical Standards and Quality has concerns with the Table because the OIG told the 5 States that were reviewed that the report would only identify the States as a group and not single out any State.

The CMS again thanks the OIG for this useful report. The OIG's recommendations actually dovetail into the plans of CMSO's MIG to continue to work with States to enforce existing policies related to the proper documentation for pediatric dental services as well as other Medicaid services. MIG will also provide assistance to States to promote provider awareness and ensure compliance with documentation requirements.

ACKNOWLEDGMENTS

This report was prepared under the direction of Robert A. Vito, Acting Regional Inspector General, and Ann O'Connor, Regional Inspector General for Evaluation and Inspections.

Mina Zadeh served as the team leader for this report. Other principal Office of Evaluation and Inspections staff from the Atlanta and San Francisco regional offices who contributed include Sarah Ambrose, Camille Harper, Scott Hutchison, Gerius Patterson, Thomas Purvis, and China Tantameng; central office staff who contributed include Ayana Everett and Kevin Farber.